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Almost fifty years ago the seed for a Canadian health care system was planted. In the ensuing years, Canadian medicare has grown into a national program, which is recognized internationally and is partially credited for Canada's high standing in the UN human development ratings. The Canada Health Act (CHA) has protected Canadians from the catastrophic economic burden of ill health by providing access to necessary medical and hospital care according to need and ability to benefit rather than income. However, technological, medical and pharmaceutical advances, as well as government restructuring and downsizing, are increasing the sites of care and thereby, eroding this protection.

This submission will highlight a number of key changes that have had and will have major implications, if not addressed, for Canadian health care in the future.

I. Changing Sites of Care

- Necessary health care is much more than hospital-based care and physician services. Indeed, health care is moving away from the traditional providers and is delivered in an array of health care settings.

II. Changes in the Funding of Health Care

- The amount of care covered under the Canada Health Act is decreasing.
- The share of publicly funded health care is decreasing.
- The increase in privately funded care is largely due to public sector costs shifting to the private sector (passive privatization).
- While more and more care is delivered in various community settings, formal home care represents 5% of total health care spending.
- A large and supportive component of care provided in most healthcare settings is derived from volunteers, families and friends.

III. Variations in Access and Utilization

- While the CHA ensures a uniform standard of care for Canadians, there is considerable variation across the country in the comprehensiveness, universality and accessibility of care provided in the community.
- Since women are not only the greater users of home care but also the providers of most informal care provided in the home and the community sector, changes in Canadian health care is having a greater impact on women than on men.

IV. Assumptions and Evidence

- The provision of care in multiple settings other than institutions is based on a number of untested assumptions and there is a paucity of research documenting its effectiveness and efficiency.

I. Changing Sites of Care

Due to economic retrenchment and better care delivery mechanisms, governments have closed or amalgamated hospitals, and reduced beds, while hospitals and other types of institutions have shortened inpatient lengths of stay and redirected services toward day surgery and other ambulatory programs. People are admitted later and discharged “quicker and sicker.” As a result, more and more health care for people of all ages has moved into the home and the community. In Canada, between 1981 and 1996/97, the number of beds decreased from 747.6 per 100,000 population to 380.4 per 100,000 population, almost a 50% decrease in beds per 100,000 population. In Ontario, inpatient hospitalizations decreased from 1437 per 10,000 population to 1022 per 10,000 population between 1990 and 1999, an almost 30% decrease in beds per 10,000 people. Meanwhile, in Ontario, the increase in day surgeries (749 per 10,000 population to 948 per 10,000 population) in the same time period did not compensate for the decrease in hospitalizations. (Canadian Institute for Health Information and Statistics Canada)

These changes in the health care landscape mean that hospitals and long term care settings are no longer the dominant site of care; rather, their role in health care has narrowed from the provision of a broad range of care to the provision of mainly acute and surgical interventions that require close, on-going surveillance and the physical presence of the patient. Much care formerly provided in hospitals, such as preparation for surgical procedures (e.g. blood and stress tests for cardiac surgery), many diagnostic procedures (e.g. blood pressure, pregnancy tests, etc.), and some hospital procedures (e.g. renal dialysis) are now performed in various sites in the community. The acuity of care has increased in hospitals and in the home and the community as “step down” clients are moved out of hospitals earlier in need of higher levels of care.

This depiction of the landscape is not to say that hospitals are no longer important or that there is a duality between institutions and the community. Rather, it emphasizes that it is no longer accurate to view health care as a linear continuum from primary to acute to long term care, with the home at one end of the continuum and the hospital at the other. Because of the exponential evolution of technologies and pharmaceuticals, care is now provided in homes, workplaces, schools, and many spaces through which people move in the course of their day. Hospitals are one important node in the

health care web. Technology is increasingly linking the hospital to care settings in the community, such that care is being provided through a new modality, a nexus of hospital and community providers and settings. What connects the different nodes in the health care web is the patient. Rather than mapping a client to existing services, an examination of the client's health and social needs, and social and housing context should dictate the best care options and the best modality partnerships to meet those needs. This new conceptualization of client-centred care requires a proactive and informed client and a broader of view of health and care.

As a complex and organic system, changes to one part reverberate to other parts. That this is the case is evident from changes that have occurred to health care either by design, accident or neglect in the past decades.

II. Changes in the Funding of Health Care

While the *CHA* ensures that care provided by physicians and in hospitals meet a set of national standards, care provided in other settings and by other providers is not safeguarded by these same principles. Universal, comprehensive, accessible and portable care only applies to "medically necessary" care provided by physicians and in hospitals. Although provinces have chosen to fund components of home and community care, they are not required to do so. This has opened the door for provincial governments to shift public costs to the private sphere. In fact, in the last 16 years the share of total health expenditures covered under the principles of the *CHA* has fallen from 57% to 45.5% of total spending (Canadian Institute for Health Information, 1999). The *CHA* now covers the minority of health spending and the majority of care is outside the ambit of this legislation.

While in 1975 the private sector accounted for 23.6% of total health spending, in 1999 it accounted for 30.4%. Upon closer examination, it has been shown that more than 80% of the growth in the private share is attributable to passive privatization, or cost shifting by government, the remainder being attributable to expanding markets and active privatization. The public-private mix ratio in health spending of 70% public and 30% private does not recognize the tremendous private sector contribution of informal caregivers (families, friends, volunteers). When one considers the value of informal caregiving, the public/private mix ratio is actually reversed with 30% public and 70% private.

Between 1975 and 1992, the annual growth rate for home-care expenditures was almost double that for total health spending (19.9% vs. 10.8%). Since 1992, home-care expenditures have risen at threefold the rate for other health spending (9.0% vs. 2.2%). Despite such dramatic growth, less than 5% of national

spending was directed to home care in 1997.

III. Variations in Access and Utilization

There are wide inter-provincial variations in home-care expenditures. Although on average Canada devoted \$69 per capita to home care in 1997, spending in New Brunswick, Newfoundland, Ontario, and Manitoba was almost threefold that in Quebec and Prince Edward Island (see Table 2). These variations persist even after adjusting for the composition of the population. A number of factors may account for these variations, which include: variations in the level of total provincial spending on health care; variations in provincial emphasis on the home as a setting for health and supportive care; and provincial variations in the pace and extent of health-system restructuring. Nevertheless, as more care formerly covered under the *CHA* moves into the unprotected zone of home and community settings, provincial variation in spending should set off alarm bells that national standards for medically necessary care are eroding. Policy makers should heed this wake-up call to revisit the definition of medical necessity and comprehensiveness under the Act.

Equally alarming is the fact that because home and community care are not considered universal entitlements (spending in these budgets is capped), eligibility criteria and service maxima have been introduced to ration care in order to stay within budgets. As a result, clients who are recently discharged from hospitals or those who are in danger of being hospitalized or placed in LTC facilities are given priority, thereby crowding out the traditional users of home and community care, i.e., the elderly and the disabled. Meanwhile these latter clients are denied service until they deteriorate and meet the criteria of being in need of institutional care. With the aging of the population, this is both a costly and short-sighted solution.

Differential access to services has been associated with the gender, age, and regional location of the client. In Ontario in 1995, the most recent year for which client-specific data are available, 261,635 clients received at least one provincially funded home-care service. The majority of clients were women (60.1%) and the elderly. Figure 1 depicts rates of home-care utilization per 1,000 population by age and gender. While the number of clients under 65 years of age is large, their rate of utilization is low (under 2%) compared to persons over 65. Women have 20% higher rates of utilization than men. The fact that utilization rates increase with age and are higher for women could reflect the needs of the elderly and persons living alone, who may have limited access to informal care.

Figure 2 shows the intensity (number and range of services) of home-care utilization by age and gender.

While average annual provincial home-care expenditures per client are substantial, at \$2,736, total expenditures for clients under 20 years of age are approximately 60% of the provincial average. In contrast, the intensity of utilization by clients over 85 years is more than 20% greater than the provincial average. Hence, not only utilization but also intensity of home-care use increases with age and is higher for women (Coyte and McKeever, 2001; National Coordinating Group on Health Care Reform and Women, 2000).

Indications of intra-provincial variations in home-care utilization have been extensively documented elsewhere (Coyte & Young, 1997; Coyte et al., 1997; Health Services Restructuring Commission, 1997; Coyte & Axcell, 1998; Coyte & Young, 1999; Young, Coyte, Jaglal, DeBoer, & Naylor, 1999; Coyte & Axcell; Coyte & Young, 1997, 1999; Coyte et al., 1997; Young et al.). While the use of home-care services follows a similar pattern of variation as that reported for many health-care services (Coyte & Young, 1999; Coyte et al., 1997; Kenney, 1993), more information is required to track the extent of such variation in order to assess its determinants and to measure the resulting consequences for Canadians.

International evidence suggests that Canada relies more heavily on institutional care than care provided in the home and community. As shown in Figure 3, the ratio of elderly living in institutions in Canada as compared to living at home and receiving home care services is three to one. In the Nordic countries this ratio is reversed, such that in Sweden and Finland the ratio is 1 to 3, and in Denmark the ratio is almost 1 to 4. (Hennesey, 1995) Also, while 10% of those over the age of 65 receive some form of formal LTC in Canada, the equivalent percentage in four Nordic countries (Finland, Sweden, Denmark, and Norway) is over 25%. Within Canada, there is variation in the reliance on LTC facility, supportive housing, and home and community care as modalities of care for the elderly. While there may be no “correct” ratio across modalities of care, there may be an optimum ratio for individual jurisdictions. An examination of values and an evaluation of care is warranted to determine the most effective and efficient ways to deliver care.

IV. Assumptions and Evidence

Policies advocating the provision of health and social services in the homes of Canadians have been supported with three commonly held assumptions. First, it is believed that people want to assume substantially greater responsibility for health-care delivered at home; want to be discharged from acute care early; want to remain in the community rather than reside in long-term-care facilities; and have family and friends willing and able to provide informal care. However, there is considerable concern about the potential responsibilities and costs that will be shouldered by family members and friends.

Moreover, the advent of the “sandwich generation” — those responsible for both children and elderly parents — raises doubts about whether assumptions regarding the supply of informal care are appropriate for the new millennium (Keating et al., 1999).

Second, it is assumed that Canadian housing and employment circumstances permit the safe shift of effective care to the home. Generally speaking, even the finest contemporary homes were not designed to facilitate the long-term provision of care and may be a sub-optimal environment both for clients and for in-home providers of informal and formal care. Complex and technically sophisticated care is being provided in the home now, but we do not know whether family members have the resources and amenities to cope safely with the changes. Moreover, while evidence demonstrates that women play the predominant caregiving roles, changes in patterns of labour-force participation and other competing demands on time raise questions about whether these supply conditions will persist.

The final commonly held assumption is that equal or better care at a lower cost will result from shifting care from institutions to the home. While home-care expenditures have risen, this increase has occurred without compelling evidence of its cost-effectiveness (Health Canada, 1992; Parr, 1996; Price Waterhouse, 1999). Systematic reviews of the international literature and reviews found very little evidence to support the cost-saving assertions for home care (Coyte & Young, 1997; Coyte, Young, & DeBoer, 1997; Health Services Restructuring Commission, 1997; Health and Welfare Canada, 1990; Parr, 1996; Price Waterhouse, 1999). Few studies reviewed were directly applicable to Canada. Essentially, the research to date has been of limited quality (Parr, 1996) and has yielded diverse cost and outcome estimates (Hughes et al., 1997).

Little is known about the impact of home care on health and lifestyle, or the extent to which the responsibility of care has shifted from institutions to patients, families, and community agencies (Parr, 1996). Moreover, there is a growing perception that unless these services are targeted to specific client groups they will not represent a cost-effective alternative to care offered in other care settings (Weissert, 1985, 1991; Weissert & Cready, 1989; Weissert, Wan, Livieratos, & Pellegrino, 1980).

Within Canada, research into the costs and benefits of home and community care is growing (Saskatchewan Health Services Utilization and Research Commission, 1998, 2000; Hollander, 1999, 2001), but much more is needed before any radical change to the health-care system.

Conclusions and Recommendations

Policy makers and Canadians need to think beyond the “hospital-home care” divide and conceptualize health care as a dynamic web of health care interactions in relation to place, space, time and technology. This vision of health care recognizes that more care is being provided not only in homes, but in workplaces and schools; being provided not only by health and social care providers but increasingly by families, pharmacists, teachers, volunteers and care recipients themselves.

Technology is simultaneously distancing and closing the ‘connect’ between health care providers and care recipients. Machines and communication devices have become “intervening variables” between providers and care recipients, moving beyond notions of “remote control” and monitoring to notions of e-health and body-machine symbioses (the virtual body), where the human body is also a site of care delivery.

While care in hospitals provides a semblance of equality of access and a degree of uniformity with respect to the quality of care, variations in socio-economic status and the physical state of personal housing, means that care when it shifts to the home becomes subject to variable standards and uneven access. As a result, quality and access have become hostage to the variability in personal resources.

Rather than perpetuating the divide between the institutional and the home and community sectors, and the divide between care provided by physicians and by other providers, Canada needs to re-examine the *CHA* principle of comprehensiveness and the definition of “necessary ” care. The setting of care delivery should be *irrelevant* to whether necessary health care is publicly funded. Policy makers need to be creative in ensuring that the principles that safeguard care provided by physicians and in hospitals are extended to today’s realities. In other words, all Canadians should be entitled to equal access to necessary health care, provided in the optimal setting by the most appropriate provider. This may be done in a number of ways, which include: extending the definition of medically necessary care under the *Canada Health Act* irrespective of the setting in which that care is received; negotiating a separate agreement between the federal government and the provinces to cover home and community care, for example, through the Social Framework Agreement; or developing a separate social insurance program for home care as both Germany and Japan have recently done. No matter which mechanism is chosen, funding must be transparent and targeted to health care, and governments and providers must be accountable to the public for the use of these funds.

Finally, the scope of publicly-funded necessary care should be flexible to meet changing contexts and

evidence. Evidence on the costs and benefits of traditional health care, social supports, social housing, and other services that may prevent more costly interventions should dictate future directions. A new lexicon and approaches for inquiry that is trans-disciplinary are necessary. Future research should include non-traditional health research disciplines to understand not only the changing nature of care but the consequences that these changes have on individuals and society at large.

Table 1: Public-Private Financing of Various Categories of Health Expenditure

	CHA Expenditures	Non-CHA Expenditures	Total
Public 1975	\$7,009.3m (74.9%)	\$ 2,351.6m (25.1%)	\$ 9,360.9m
1999	\$36,852.8m (61.6%)	\$22,983.4m (38.4%)	\$59,836.2m
Growth rate p.a.	7.2%	10.0%	8.0%
Private 1975	\$ 344.9m (11.9%)	\$ 2,554.3m (88.1%)	\$ 2,899.2m
1999	\$ 2,332.3m (8.9%)	\$23,844.6m (91.1%)	\$26,176.9m
Growth rate p.a.	8.3%	9.8%	9.6%
Total 1975	\$ 7,354.2m (60.0%)	\$ 4,905.9m (40.0%)	\$12,260.1m
1999	\$39,185.1m (45.6%)	\$46,828.0m (54.4%)	\$86,013.1m
Growth rate p.a.	7.2%	9.9%	8.5%
Private share 1975	4.7%	52.1%	23.6%
1999	6.0%	50.9%	30.4%

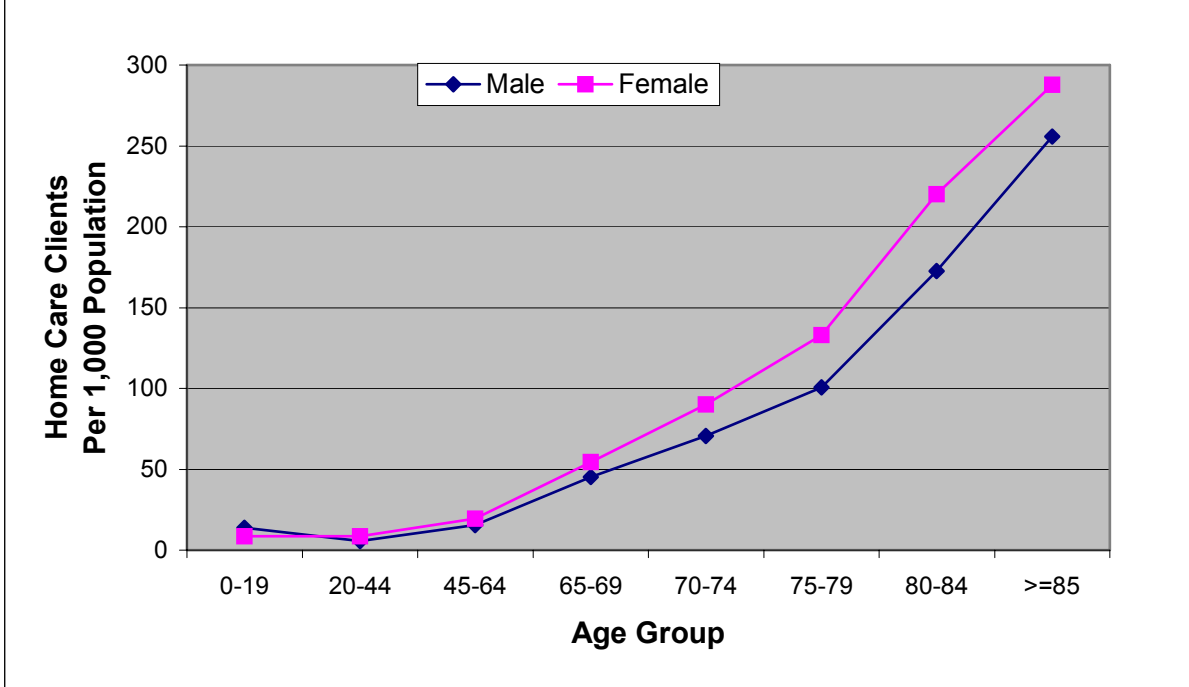
Note: CHA Expenditures refers to expenditures on hospitals and physicians. Non-CHA Expenditures refers to all others. Source: Canadian Institute for Health Information (1999).

Table 2: Interprovincial Public Home-Care Expenditures per Capita, 1997

Newfoundland	\$92.25
Prince Edward Island	\$34.26
Nova Scotia	\$79.94
New Brunswick	\$94.52
Quebec	\$37.36
Ontario	\$91.08
Manitoba	\$90.50
Saskatchewan	\$68.71
Alberta	\$52.45
British Columbia	\$62.06
Canada	\$69.20

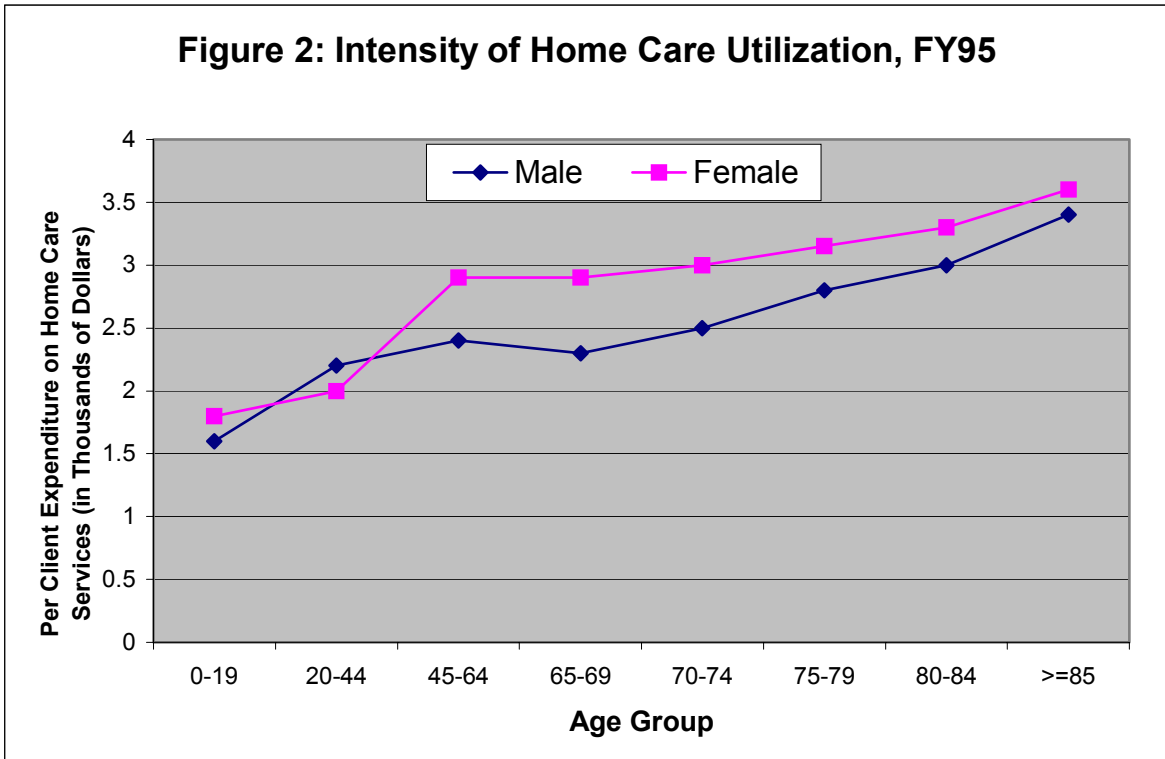
Source: Health Canada (1998).

Figure 1: Home Care Utilization Rates by Age and Gender in Ontario, FY95



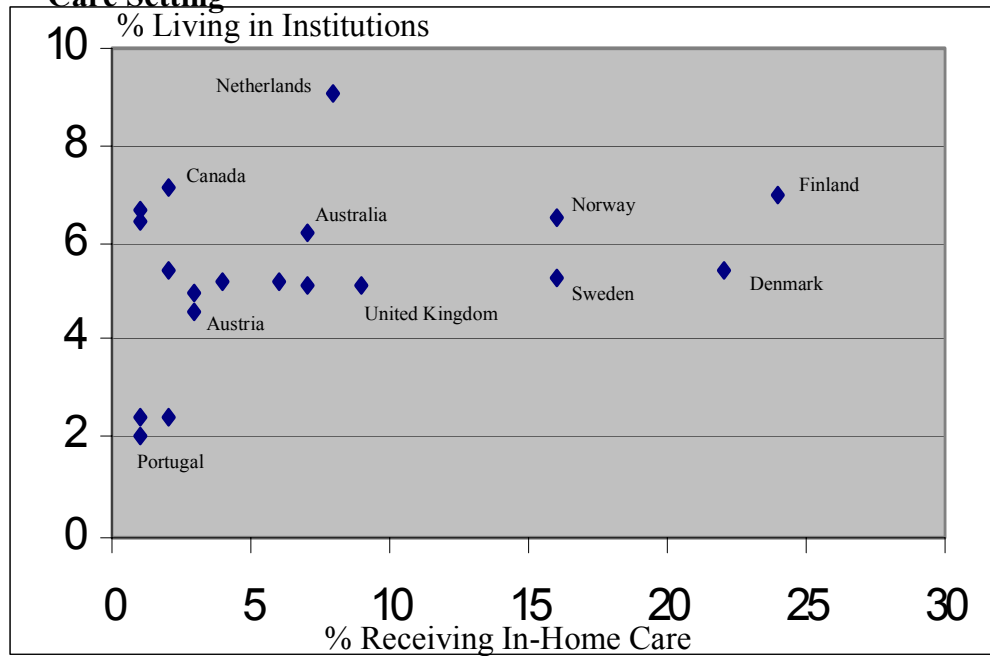
Source: Coyte and McKeever (2001)

Figure 2: Intensity of Home Care Utilization, FY95



Source: Coyte and McKeever (2001)

Figure 3: Proportion of the Elderly (65+) Receiving Care by Health Care Setting



Source: Hennesey (1995)

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